

		FOR OHF USE					

LL 1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0040915</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Fair Oaks Health Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>471 West Terra Cotta</u> <u>Crystal Lake</u> <u>60014-3434</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>McHenry</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Joyce Surdick</u> (Title) <u>Administrator</u>	
Telephone Number: <u>(815)455-0550</u> Fax # <u>(815)455-0608</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Alan H. Runde - Manager</u> (Firm Name & Address) <u>Wipfli Ullrich Bertelson, LLP</u> <u>1200 North Mayfair Road, Ste 450, Milwaukee, WI 53226</u> (Telephone) <u>(414)431-9300</u> Fax # <u>(414)431-9303</u>	
IDPA ID Number: <u>364016275001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>5/1/95</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
IRS Exemption Code <u>501(c)(3)</u>			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Amy Seils</u> Telephone Number: <u>(414)431-9315</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Fair Oaks Health Care Center# 0040915 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>46</u>	Skilled (SNF)	<u>46</u>	<u>16,836</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>46</u>	TOTALS	<u>46</u>	<u>16,836</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,920</u>	<u>11,206</u>	<u>2,134</u>	<u>15,260</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,920</u>	<u>11,206</u>	<u>2,134</u>	<u>15,260</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.64%

D. How many bed-hold days during this year were paid by Public Aid?

224 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 5/95

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 5/95 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 40 and days of care provided 2,125Medicare Intermediary United Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number

Fair Oaks Health Care Center

0040915

Report Period Beginning:

1/1/00

Ending:

12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	105,568	3,920	16,657	126,145		126,145		126,145		1
2	Food Purchase		62,393		62,393		62,393		62,393		2
3	Housekeeping	87,269	7,727	1,443	96,439		96,439		96,439		3
4	Laundry	17,277	3,288	6,461	27,026		27,026		27,026		4
5	Heat and Other Utilities			49,952	49,952		49,952		49,952		5
6	Maintenance	39,681	4,745	12,194	56,620		56,620		56,620		6
7	Other (specify):*										7
8	TOTAL General Services	249,795	82,073	86,707	418,575		418,575		418,575		8
	B. Health Care and Programs										
9	Medical Director			10,000	10,000		10,000		10,000		9
10	Nursing and Medical Records	695,779	37,593	79,471	812,843		812,843		812,843		10
10a	Therapy	102,538	1,746	2,105	106,389		106,389		106,389		10a
11	Activities	34,306	1,040	3,704	39,050		39,050	(920)	38,130		11
12	Social Services	27,112	241	1,225	28,578		28,578		28,578		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	859,735	40,620	96,505	996,860		996,860	(920)	995,940		16
	C. General Administration										
17	Administrative	57,211			57,211		57,211		57,211		17
18	Directors Fees										18
19	Professional Services			154,200	154,200		154,200		154,200		19
20	Dues, Fees, Subscriptions & Promotions			2,862	2,862		2,862		2,862		20
21	Clerical & General Office Expenses	33,490	2,898	22,947	59,335		59,335		59,335		21
22	Employee Benefits & Payroll Taxes			143,950	143,950		143,950		143,950		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,325	13,325		13,325		13,325		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration	90,701	2,898	337,284	430,883		430,883		430,883		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,200,231	125,591	520,496	1,846,318		1,846,318	(920)	1,845,398		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number

Fair Oaks Health Care Center

#0040915

Report Period Beginning:

1/1/00

Ending:

12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			78,838	78,838		78,838		78,838			30
31	Amortization of Pre-Op. & Org.			4,260	4,260		4,260		4,260			31
32	Interest			240,392	240,392		240,392		240,392			32
33	Real Estate Taxes			47,637	47,637		47,637		47,637			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			371,127	371,127		371,127		371,127			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,560	24,576	66,136		66,136		66,136			39
40	Barber and Beauty Shops			(35,302)	(35,302)		(35,302)		(35,302)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,530	25,530		25,530		25,530			42
43	Other (specify):*			16,956	16,956		16,956	(16,956)				43
44	TOTAL Special Cost Centers		41,560	31,760	73,320		73,320	(16,956)	56,364			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,200,231	167,151	923,383	2,290,765		2,290,765	(17,876)	2,272,889			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fair Oaks Health Care Center

0040915

Report Period Beginning:

1/1/00

Ending:

12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(920)	11		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,000)	43		24
25	Fund Raising, Advertising and Promotional	(2,210)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule 5A	(4,746)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (17,876)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (17,876)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0040915
Report Period Beginning: 1/1/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Gifts & Parties	\$ (4,746)	43
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
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70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(4,746)	90

Summary A

0040915

Report Period Beginning:

1/1/00

Ending:

12/31/00

[illegible]

Facility Name & ID Number Fair Oaks Health Care Center

0040915

Report Period Beginning:

1/1/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WISH	100%	Geneva Lakes Manor				
		Wild Rose Manor				
		Holton Manor				
		Sheltered Village				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Fair Oaks Health Care Center # 0040915 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fair Oaks Health Care Center# 0040915

Report Period Beginning:

1/1/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Wisconsin Illinois Senior Housing Inc. (WISH)
 Street Address 13185 Green Mountain Drive
 City / State / Zip Code Lakewood, CO 80228
 Phone Number (313)980-0611
 Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative Costs	Direct Cost	4,672,706	5	\$ 4,292	\$	2,165,201	\$ 1,989	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,292	\$		\$ 1,989	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Eaton Vance Mgmt-Series A/B		X	Purchase Bldg & Equipt	\$23,717.00	8/20/99	\$ 2,657,461	\$ 2,114,521	8/01/29	7-8%	\$ 240,392	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$23,717.00		\$ 2,657,461	\$ 2,114,521			\$ 240,392	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,657,461	\$ 2,114,521			\$ 240,392	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fair Oaks Health Care Center

0040915 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	37,433	2
3. Under or (over) accrual (line 2 minus line 1).	\$	37,433	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	10,204	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	47,637	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995		8
	1996		9
	1997		10
	1998	57,500	11
	1999	37,433	12

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet:

17,003

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	46		1999		\$ 1,328,800	\$ 34,072	39	\$ 34,072		\$ 46,530	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	New Concrete			2000	5,500	61	15	61		61	9
10	Removal of Tree Debris			2000	660	7	15	7		7	10
11	Removal & Replacement of Concrete			2000	5,500	23	20	23		23	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 1,340,460	\$ 34,163		\$ 34,163		\$ 46,621	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 308,762	\$ 44,339	\$ 44,339		5-10 years	\$ 71,647	37
38	Current Year Purchases	13,438	310	310		5-10 years	310	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 322,200	\$ 44,649	\$ 44,649			\$ 71,957	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$			\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$			\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,662,660	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 78,812	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 78,812	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 118,578	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist		1838	hrs	\$ 61,756		\$		1,838	\$ 61,756	1
2	Licensed Speech and Language Development Therapist		784	hrs	23,825				784	23,825	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist		421	hrs	16,957				421	16,957	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							
10	Academic Education			hrs							10
11	Exceptional Care Program										11
12											12
13	Other (specify):										13
14	TOTAL				\$ 102,538		\$	\$	3,043	\$ 102,538	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 28,131	\$ 28,131	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,923)	192,961	192,961	3
4	Supply Inventory (priced at cost)	5,784	5,784	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	341,005	341,005	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 567,881	\$ 567,881	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	200,000	200,000	13
14	Buildings, at Historical Cost	1,329,624	1,329,624	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	334,372	334,372	16
17	Accumulated Depreciation (book methods)	(120,594)	(120,594)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	88,145	88,145	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(5,680)	(5,680)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,825,867	\$ 1,825,867	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,393,748	\$ 2,393,748	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 65,347	\$ 65,347	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	105,316	105,316	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,204	10,204	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTERCOMPANY	1,847	1,847	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 182,714	\$ 182,714	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,114,521	2,114,521	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,114,521	\$ 2,114,521	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,297,235	\$ 2,297,235	46
47	TOTAL EQUITY(page 18, line 24)	\$ 96,513	\$ 535,039	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,393,748	\$ 2,832,274	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 403,007	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 403,007	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	132,032	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Reverse prior year net acquisition costs	(1,772,840)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,640,808)	17
	B. Transfers (Itemize):		
18	Record Forgiveness of Debt and payables	1,334,314	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,334,314	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 96,513	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,052,319	1
2	Discounts and Allowances for all Levels	8,166	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,060,485	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	165,504	6
7	Oxygen	1,224	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 166,728	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	11,050	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	43,222	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,652	19
20	Radiology and X-Ray	14,710	20
21	Other Medical Services	53,082	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 126,716	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS REVENUE	53,928	28
28a	BEDHOLD REVENUE	14,940	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 68,868	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,422,797	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	418,575	31
32	Health Care	996,958	32
33	General Administration	430,785	33
	B. Capital Expense		
34	Ownership	371,127	34
	C. Ancillary Expense		
35	Special Cost Centers	47,790	35
36	Provider Participation Fee	25,530	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,290,765	40
41	Income before Income Taxes (line 30 minus line 40)**	132,032	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 132,032	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Fair Oaks Health Care Center

0040915

Report Period Beginning: 1/1/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,056	2,056	\$ 52,188	\$ 25.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,295	10,541	199,928	18.97	3
4	Licensed Practical Nurses	4,855	5,104	97,911	19.18	4
5	Nurse Aides & Orderlies	27,210	29,710	322,850	10.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,110	2,110	82,188	38.95	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,906	2,023	22,000	10.87	9
10	Activity Assistants	1,749	1,749	12,306	7.04	10
11	Social Service Workers	1,665	1,757	27,112	15.43	11
12	Dietician					12
13	Food Service Supervisor	1,953	2,150	26,315	12.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,439	5,951	52,780	8.87	15
16	Dishwashers	3,032	3,434	26,315	7.66	16
17	Maintenance Workers	1,845	2,048	39,681	19.38	17
18	Housekeepers	10,193	10,689	87,269	8.16	18
19	Laundry	2,124	2,231	17,277	7.74	19
20	Administrator	1,968	2,757	57,211	20.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,285	1,335	33,490	25.09	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,815	1,957	22,902	11.70	31
32	Other Health C: Ther Asst	852	905	20,350	22.49	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	81,352	88,507	\$ 1,200,073 *	\$ 13.56	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	157	\$ 7,371	L1, C3	35
36	Medical Director	36	10,000	L9, C3	36
37	Medical Records Consultant	30	1,297	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	600	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	41	2,711	L11, C3	44
45	Social Service Consultant	15	966	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	375	\$ 22,945		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	166	\$ 6,665	L10, C3	50
51	Licensed Practical Nurses	846	28,337	L10, C3	51
52	Nurse Aides	31	888	L10, C3	52
53	TOTAL (lines 50 - 52)	1,043	\$ 35,890		53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Stephanie Sherman	Administrator	0%	\$ 18,476	Workers' Compensation Insurance	\$ 13,006		IDPH License Fee	\$
Joyce Surdick	Administrator	0%	38,735	Unemployment Compensation Insurance	9,641		Advertising: Employee Recruitment	
				FICA Taxes	87,343		Health Care Worker Background Check	
				Employee Health Insurance	31,884		(Indicate # of checks performed _____)	
				Employee Meals			IHCA	2,109
				Illinois Municipal Retirement Fund (IMRF)*			UHF	150
				Life Insurance	773		Chamber of Commerce	385
				Other Employee Benefits	1,303		Task Force	30
							Professional Regulations	100
							Various Other Dues & Subscriptions	88
							Less: Public Relations Expense	()
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)	
			\$ 57,211		\$ 143,950			\$ 2,862
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							CME Conf, Florida (3 people)	1,994
							In-State Travel	
							Travel to in-state meetings, conferences	4,722
							Seminar Expense	771
							Education/Seminars	4,456
							Entertainment Expense	11
							Business Meals	68
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL	\$ 12,022
			\$			\$		
C. Professional Services								
Vendor/Payee	Type		Amount					
Wipfli Ullrich Bertelson	Accounting		\$ 2,000					
Altschuler-Melvoir	Accounting		853					
WISH	Accounting		7,000					
Price, Donoghue, Ridenour	Accounting		4,262					
Holleb & Coff	Legal		458					
Figliulo & Silverman	Legal		250					
Duane & Morris	Legal		6,158					
Beck, Chaet, & Moloney	Legal		44					
CME	Management Fees		95,582					
WISH	Management Fees		20,975					
ADP	Payroll Processing		16,618					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)								
			\$ 154,200					

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Fair Oaks Health Care Center

STATE OF ILLINOIS

0040915

Report Period Beginning:

1/1/00

Ending:

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12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,097 Line L4, C3
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 25,530
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Price Donoghue Ridenour The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Copy will be sent when audit is complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? n/a
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.